BHSF Form MPP-ED
Rev. 08/04
II

Medicaid Purchase Plan

Effective Date of Coverage Request

Complete this form, as follows, in order to explore and document the months of coverage for Medicaid Purchase Plan when there is premium responsibility due by the applicant. File the original with the application and give a copy to the applicant.

1. Circle the month of application.

2. Highlight the month of application and any subsequent months up through the month following the eligibility determination month. If retroactive coverage has been requested, highlight the months (up to three months preceding the application month) for which all eligibility factors were met.

3. Put an "X" in each block of the highlighted months for which a premium will be owed and enter the premium amount in the space below the block.

4. Discuss the advantages of the proposed months of coverage based on the applicant's needs. Obtain the applicant's decision regarding the months of coverage requested.

5. Record the applicant's decision regarding the months of coverage being requested. Both the applicant and the agency representative must sign and date this document.

Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Start date of coverage requested: _____
Month/Year

6. If the applicant does not want to continue with the request for coverage because of premium liability, have the applicant complete and initial the withdrawal block below:

I wish to withdraw my ☐ application for the Medicaid Purchase Plan ☐ request for retroactive coverage because I do not wish to pay a premium for this coverage. _____ (applicant's initials)

_____ _____
Signature of Applicant Date

_____ _____
Signature of Agency Representative Date